PATIENT EDUCATION IN PRIMARY CARE:

KEY TO ACTIVE VETERAN PARTICIPATION

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WELCOME to our new resource for patient education and primary care![1]

- **WHAT IS IT?** The purpose of this tool is to provide a mechanism to help meet the challenges of incorporating effective patient teaching into primary health care.
- **WHO IS IT FOR?** VA Primary Care Teams, Patient Health Education Coordinators or Patient Health Education Committee chairs, VISN and VAMC decisionmakers

MAKING THE WEB A USEFUL PATIENT EDUCATION RESOURCE IN PRIMARY CARE

In less than a decade the Internet and World Wide Web have become synonymous with unparalleled access to information. A 1999 Harris poll has estimated that of 88 million people on-line in the US, 68% or 60 million have used the Internet in the last 12 months to look for healthcare information related to a particular disease or medical condition. The most common disease searches were for depression, allergies or sinus, cancer, bipolar disorder, migraine, anxiety disorder, heart disease and sleep disorders. Though older adults are less likely to have computers, a 1996 survey sponsored by SeniorNet found that 30% of adults 55 to 75 owned a computer, a 43% increase from the 1994 survey. While those with at least some college were more likely than those with less education to have a computer, 64% of non-owners said that at least one of their children has a computer.

Given the time constraints in busy primary care clinics, the exploding amount of health information, and the logistics of maintaining availability of materials in off-site locations, increasing staff and patient access to health information on-line should be a priority. But there are challenges. Access to computers in many medical centers, especially those with on line connections, may be limited. Many lower income veterans may not own a computer. Staff who have not grown up with computers, are less confident that they can access information. Even when an on-line connection is made, the user is faced with a dizzying array of web sites and the daunting task to identify accurate information.

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[1]**This publication may be duplicated.**

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Establishing the Connection

Many VAMCs and other health systems have established an Intranet--or internal network for authorized users--to provide access to health information for staff and patients. For example, the VAMC in Nashville, TN is developing an Intranet Home Page accessible by other VAMCs(< http://152.130.31.149/vamc >) that offers welcome information for veterans and visitors, and access to the Patient Health Education Healthy Life Home Page. From this page, users can access a class list, closed circuit television programs, "Teach Tools" or one-page information sheets on a variety of topics, and the VHA Cancer program which includes cancer specific patient education resources. While staff access this page from unit or clinic-based terminals and print out information for specific patients, veterans can also access the information via two computers in the Healthy Life Learning Resource Center. A technician in the center is also available to help staff and veterans use on-line resources.

At Ohio State University (OSU) Medical Center the Health and Wellness Home Page (http://www.osumedcenter.edu/health_wellness/default.asp) provides access to a myriad of informational resources through both a local Intranet and the Internet. This is because many of their primary care sites do not have access to the medical center's Intranet. Any Internet user, therefore, has access to nearly 1600 patient education resources if they download Adobe Acrobat software required to view these documents. Users are asked to agree not to edit or alter the materials and to print out only individual copies for personal or patient use.

At the Fountain of Healthy Living Learning Center at the Albuquerque VAMC, veterans are offered access to on-line information. Two of the Center's volunteers are helping to create the Center's website (http://www.va.gov/station/501-albuquerque/fountain.html) which currently offers information about the center and links to selected health websites by topic and date of national health observance. Since one volunteer also works with the public library, he is able to encourage veterans who don't have personal computers to check out access at the local library.

Through the University of Utah Hospitals and Clinics' Patient Education Home Page (www.med.utah.edu/pated), Intranet users can access 700 of the 1600 patient education tools that have been catalogued. The system is available for use in the two hospitals and 40 clinics, including some remote sites. Both Intranet and Internet users can access the educational events data base of classes, support groups, workshops, seminars and community events; an author's guide for health providers writing new materials for the home page; and a link to the government sponsored Healthfinder Home Page.

Encouraging Staff Use

Having computers connected to the local Intranet and Internet that are accessible to clinical staff is a necessity if they are to use the on-line resources. But accessibility is not enough--staff need to feel confident that they can access useful resources. The University of Utah Hospitals and Clinics recently evaluated a Patient Education Home Page Demonstration Project* with three areas of the medical center--Cardiology, Oncology and Nutrition Care Services. Project leaders were identified in each area and practical inservice training sessions provided upon request to all participating services in the various units and clinics. These included hands-on assignments including finding and printing patient education resources.

Results showed that those services where most staff completed the optional training program were more likely to be comfortable using the computer. In all, 62% of one hundred respondents to the final survey did use the Home Page during the project, but they did not use it frequently. However, the Home Page was viewed as a positive addition to clinical practice and staff liked the accessibility, variety and content of materials. Continued need for staff training, computer/printer unreliability, poor access to computers and the time required to obtain information were identified as problems.

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Evaluating Web Sites

A major concern among clinicians is that there is much information on the Internet that is inaccurate and out-of-date. An important strategy in addressing this concern is determining how to help staff and consumers alike evaluate the massive amounts of information that are available. Several institutions have set up mechanisms to review websites that are provided to patients and/or linked directly via the medical center's web site. For example, at the Albuquerque VAMC, the Advisory Team for the Fountain for Healthy Living reviews monthly the content of websites that are frequently recommended to veterans. A health-related web site evaluation form is available through the School of Public Health web address at Emory University in Atlanta(http:www.sph.emory.edu/WELLNESS/instrument.html). The form guides users' assessment of content accuracy and currency, appropriateness of affiliation, audience, external links and structure.

At the USC/Kenneth Norris Jr. Cancer Hospital in Los Angeles, a 23-page patient library web site list is about to become part of the patient education resource materials for each unit. Developed and updated by the Patient Care Services Professional Practice Council, the list includes web site names and addresses by major diagnostic category, a brief description of each site, and a review date. Clinicians will be able to use this list to access information on their units and print out specific materials for themselves and their patients. For more information on this list contact Ellen Sitton, MSN, OCN, at 323/865-3085 or e-mail <sitton_e@mikey.hsc.usc.edu>.

Other contacts for this article include: Carol Maller, MS, RN, CHES, Patient Health Education Coordinator, VAMC Albuquerque, NM COM 505/265-1711, Ext. 4656; FTS 700/572-4656; Barbara Meadows, Chief Library Service, VAMC Nashville, TN, COM 615/327-4751, Ext. 5524, FTS 700/850-4751, Ext.5524; Sandra Cornett, PhD, RN, Program Manager, Consumer Health Education, The Ohio State University Medical Center, Columbus COM 614/293-3191; Jackie A.Smith, Ph.D, Patient Education Coordinator, University of Utah Hospitals and Clinics, Salt Lake City COM 801/581-4804.

**Smith, J.A. and Bray, B.E. (1999) Integrating access to patient education resources using computer technology: an intranet demonstration project. Presented at the Association of Health Care Research Conference, April 1-3, 1999, Breckenridge, CO.*

PLAN FOR MAY 1999 HEALTH OBSERVANCES

(Materials available from sponsoring organizations)

Arthritis Month
800/283-7800

Asthma and Allergy Awareness Month
800/7-ASTHMA

Digestive Diseases Awareness Month
202/544-7497

High Blood Pressure Month
301/251-1222

Osteoporosis Prevention Month
202/223-2226

Stroke Awareness Month
800/STROKES

For a complete list of national health observances by month and contact information go to the National Health Information Center's web site at <http://nhic-nt.health.org/pubs/> or call to order a single copy of the associated publication at 800/336-4797.

HOW DO WE KNOW PATIENT EDUCATION WORKS?

CHRONIC DISEASE SELF-MANAGEMENT

This six-month clinical trial evaluated the effectiveness of a community-based self-management program for chronic disease designed for use with a heterogeneous group of chronic disease patients. Study subjects had to have a physician confirmed diagnosis of heart disease, stroke, arthritis, or chronic lung disease. Built around the concept of increasing self-efficacy to manage disease, the program includes 7 weekly 2-hour sessions that cover exercise, use of cognitive symptom management techniques, nutrition, fatigue and sleep management, use of community resources, problem solving, communication with health professionals, and other issues common to a range of chronic diseases. At six months, the experimental group demonstrated significant improvements in weekly minutes of exercise, frequency of cognitive symptom management, communication with physicians, self-reported health, health distress, fatigue, disability and social/role activities limitations. They also had fewer hospitalizations and days in the hospital. No differences were found in pain/physical discomfort, shortness of breath, or psychological well-being.

Lorig et al. (1999) Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. Medical Care. 37(1): 5-14.

FAMILY INVOLVEMENT IN CARE

A national telephone survey of 1,800 recently discharged patients and their carepartners (68% spouse or significant other) explored perceptions of the hospital experience. Carepartners most often reported problems in the areas of emotional support (23.9%), discharge planning (20.3%) and family participation (17.3%). Variables associated with more frequent carepartner problem reports included emergency admission, nonsurgical admission, younger carepartner age, very low carepartner income, non-involvement of the patient's regular doctor, poorer patient self-rated health, less than daily visits to patient by carepartner, and less time spent with patient after discharge. Given the important role that family members and friends often play in helping patients cope with illness, the presence of these risk factors may alert clinicians to the possibility of care partner problems and the need for intervention.

Vom Eigen, K.A. et al. (1999) Carepartner experiences with hospital care. Medical Care. 37(1): 33-38.

TALKING WITH PATIENTS ABOUT USE OF ALTERNATIVE THERAPIES

A 1997 survey showed that 34% of a random sample of adults in the US had used alternative therapies within the past year, mostly to treat a serious condition. While the majority were also seeing a conventional physician for the same condition, at least 3/4 did not discuss the alternative therapy with this physician. A recent article in Primary Care reviews the demographics of alternative therapy use and outlines a practical approach for clinicians to use to talk with their patients about these therapies and negotiate regimens that incorporate patients' interests in complementary medicine.

Lazar, J.S. and OíConnor, B.B. (1997) Talking with patients about their use of alternative therapies. Primary Care.24(4): 699-714.

PATIENT EDUCATION/PRIMARY CARE PROGRAM NOTES

Dietitians Experiment with New Ways to Help Veterans Change Lifestyles

Faced with decentralization of services and lack of attendance at multi-session classes, outpatient dietitians at the Phoenix VAMC have reorganized the Heart Healthy classes to be more responsive to the current environment. Now run as a single session program both at the medical center and in the two affiliated primary care outreach clinics, the class is oriented toward helping veterans learn about relevant risk factors and identify a realistic lifestyle change that they can work on for the next month. For example, some veterans have decided to start or expand an exercise program, reduce fried foods in their diet or add more fruits and vegetables. Rather than having a second class, each participant is now scheduled for an appointment one month later with the dietitian to review progress.

While not a formal prerequisite for participation in other related classes, attendance at the Heart Healthy program is often the catalyst for interest in other nutrition-related topics. For example, the dietitians have recently begun a shopping class for veterans and significant others in conjunction with a local supermarket. The class meets at the grocery store to discuss such topics as how to select leaner cuts of meat and read labels. To overcome a common problem encountered in this class--difficulty reading labels because of low vision--2" by 6" bookmark magnifiers have been purchased with resources from Public Affairs and imprinted with the VA logo. Dietitians will demonstrate the use of the magnifier during the "Heart Healthy" session; each veteran who actually participates in the shopping class receives one.

Ninety-minute cooking demonstrations in the new ambulatory care facility with food purchased with Volunteer Service contributions complement the shopping class. Currently focussed on demonstrating low-fat, economical entrees, this program offers attendees an additional benefit--samples of all dishes prepared!

Contact: Sheila Woodroffe, MS, RD, Clinical Dietitian, Phoenix VAMC, COM 602/ 277-5551, Ext. 6344; FTS 700/761-6344.

Collaboration/Reinforcement Key to Medication Teaching in Primary Care

Time constraints, frequent individual patient barriers to learning, and complex medication regimens often interfere with effective medication instruction. However, collaborative teaching by primary care clinicians and pharmacists reinforced by distribution of Patient Medication Information (PMI) sheets can overcome barriers, encourage patient compliance and reduce medication errors. Carolyn Stanley-Tilt, a nurse practitioner in the Salem (VA) VAMC's psychiatric primary care clinics, depends on clinical pharmacists assigned to primary care for consultation and also to work with those patients who have especially complicated medication requirements. She also counts on pharmacists who dispense medication to review the basics of how to take prescribed drugs, risks and benefits, and food/drug interactions. Yet during most clinical encounters, she feels that she has a critically important role to help veterans take an active role in their care. In addition to discussing the purpose and possible side effects of the medication, she emphasizes three points:

- *Generic name of medicine* - She finds that it demystifies the clinical process when patients actually know the name of the medicine they are taking rather than simply "heart pill" or "low blood pill." This also prevents veterans from thinking that their "heart pill" is necessarily like their friend's "heart pills." Teaching the generic name means that the patient will not be confused by an unknown drug name on the pill container. For example, rather than using the word Valium, she teaches diazepam, the generic name for the drug that will be dispensed.

- *Dosage* - Given changes in the generic drugs purchased by the VA, she believes patients need to know their specific dosage. Then if they know they are to take 20 milligrams, they will not be confused if the dispensing pharmacist tells them to take one or two pills depending on the strength of the drug currently available in the formulary.

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• *Reading the label* - Patients (or significant others if they are not able to read) need to be able to find the name of the medication and dosage on the label. If an unfamiliar name is on the container, they should know to call the pharmacist or primary care clinician to check on the accuracy of the prescription. This is particularly important for those veterans who receive mailed medication.

Nina Resch, Pharm.D., a clinical pharmacist assigned to primary care at the Albuquerque, New Mexico VAMC, uses a patient-centered approach to address the complex needs of veterans referred to her by primary care clinicians. She finds that it is timesaving in the long run to do an in-depth assessment of a patient's situation before embarking on an action plan. When the veteran brings his or her pill containers to the clinic, she begins by asking for a description of how each medication is taken. She probes why each medication has been prescribed, how frequently, under what circumstances and whether there are any side effects or other problems. Although she tries to ask each person how they like to learn, she has found that most patients like to have a clinician go over the instructions as well as provide a PMI as a reference. She teaches the use of pill boxes with almost all polypharmacy patients and may coordinate use of a case manager if the patient or significant other is not able to fill the boxes correctly. She also encourages patients to keep a listing of all their curent medications and dosages.

Contact: Carolyn Stanley-Tilt, MSN, RNCS, FNP, Family Nurse Practitioner, Salem (VA) VAMC COM 540/982-2463, Ext. 2613; FTS 700/937-2613.
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NEW Feature: Performance Improvement Training

MOTIVATIONAL INTERVIEWING: Brief Intervention to Encourage Behavior Change-- The Smoking Example

Every quarter, Patient Education and Primary Care will offer the opportunity to earn one hour of performance improvement training credit for a patient education topic of importance to primary care clinicians. To earn this credit choose one of the following two options:

❑ **Read the attached summary *"Motivational Interviewing: Brief Intervention to Encourage Behavior Change,"* and provide brief answers to the following questions. Turn these in to your supervisor along with this two page content description.**

OR

❑ **Organize a one-hour brown bag journal club or set aside time during a staff or team meeting to read the original article —*Rollnick, S., Butler, C.C., and Stott, N. (1997) Helping smokers make decisions: the enhancement of brief intervention for general medical practice. Patient Education and Counseling, 31:191-203*—and discuss the following questions. Turn in a master list of journal club participants along with the content description.**

QUESTIONS:

1. What strategies do primary care clinicians in your facility use now to encourage patient involvement in behavior change decisions?
2. How do you think incorporating assessment of motivation for behavior change and confidence in ability to change behavior could strengthen current counseling interventions?
3. What would be the barriers for staff in utilizing these strategies?

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SUMMARY: Motivational Interviewing: Brief Intervention to Encourage Behavior Change--The Smoking Example[2]

Helping people change can be a frustrating process. Clinicians are often pressed for time yet behavior change is a slow, incremental process. They often perceive that patients don't want to change and that they don't possess the skills to help them change. Yet research shows that when clinicians are viewed as the expert providers of information and the patients as experts in what they believe will be feasible in their own lives, progress toward meaningful behavior change is possible. When clinicians explore patients' ideas and concerns, the outcomes are better, and when patients play an active role in the intervention, satisfaction, symptoms and bio-chemical parameters of disease control improve.

Based on theories of client-centered interviewing, stages of change and self-efficacy, motivational interviewing has been defined as "a directive, client-centered counseling style for helping clients explore and resolve ambivalence about behavior change." The goal of motivational interviewing is not to persuade clients that they should be concerned about a behavior or for the clinician to provide solutions to problems, but rather to elicit involvement by the client in problem definition and solu-tion exploration. The clinician can then work with the client to develop an action plan consistent with his or her own beliefs and values. Resistance is a signal not to blame or label the client, but for the counselor to back off and change his or her approach.

This article describes a brief intervention for primary care practice that uses principles of motivational interviewing to help smokers make decisions about their smoking behavior. It is being tested in a clinical trial in the United Kingdom. So far, 24 primary care physicians have recruited 270 patients and used a mean time of 9.69 minutes per smoker to deliver the intervention. Although data is not yet available on the outcomes of the trial, clinicians report that they are more optimistic that this method will effect smoking behavior (mean score of 6.9 on a 1 to 10 scale with 10 being most optimistic) than standard brief advice (mean 3.0). They also rated this method very acceptable to patients and potentially very useful to other primary care clinicians.

The intervention is divided into three parts:

I. Quick Assessment

The clinician begins with questions such as "What sort of smoker are you?" to build rapport and communicate that he or she will not just be lecturing about stopping smoking. The goal is for the clinician to understand how smoking fits into the patient's life. Then two assessment questions are asked about motivation to quit and confidence in ability to quit: a) "If on a scale of 1 to 10, 1 is not at all motivated to give up smoking and 10 is 100% motivated to give up, what number would you give yourself at this moment?" and b) "If you were to decide to give up smoking now, how confident are you that you would succeed? If on a scale of 1 to 10, 1 means not at all confident and 10 means 100% confident that you could give up and remain a non smoker, what number would you give yourself?"

II. Patient Identifies Problems and Solutions

Addressing motivation to quit first, the clinician explores with the patient why they chose the number they did. Another good follow-up question might be "What would need to happen for you to get from the current number to a higher number?" Depending on the response it may be helpful to ask what the patient likes and does not like about smoking. The clinician can summarize both sides and ask the patient "Where does that leave you now?" Or he or she can ask if the patient would like up-to-date information about smoking risks to help in decisionmaking. Active listening and providing neutral feedback to the patient about what he or she is saying are important to encourage involvement.

[2]**The following information is summarized from the following journal article—***Rollnick, S., Butler, C.C., and Stott, N. (1997) Helping smokers make decisions: the enhancement of brief intervention for general medical practice. Patient Education and Counseling. 31:191-203.*

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Exploring confidence in ability to quit, the clinician can ask the patient why the specific numbered response was chosen and what would need to happen to move to a higher number. The clinician could also ask "How can I help you get from where you are now to a higher number?" It is important here to help the patient focus first on a general problem area--such as withdrawal, weight gain, or stress--and then brainstorm solutions. Encouraging the patient to identify solutions first is critical--the clinician should not jump in to offer a single, simple solution but rather, in the course of the discussion, add ideas to those offered by the patient. Exploring the strategies that have worked in the past for the patient or for others can be used as another approach. At the end of this phase the patient chooses the best option for change.

III. Target and Follow-up

The focus here is to help the patient set a measurable goal such as cutting down on the number of cigarettes or actually quitting. The goal may also relate to a factor that influences smoking such as beginning an exercise program, taking a stress management class, or changing diet. Also at this time it is important for the clinician to find out what help the patient needs to attain the goal--for example, follow-up visits, telephone calls, advice on nicotine replacement, or community referral.

If the patient is not ready to set a goal, then the focus becomes keeping the communication open such as by saying, "Things may change in the future--can we talk about this again next year?"

COMING IN JULY — ***Motivational Interviewing: The Diabetes Example***

TELL US ABOUT THE TOPICS YOU WOULD LIKE TO SEE COVERED IN FUTURE ISSUES.

Do you have any successful patient education strategies that you would like to share with us?

Contact Barbara Giloth (773/743-8206 or email bgilot1@uic.edu), Carol Maller (700/572-2400, ext 4656 or email maller.carol@albuquerque.va.gov) or Charlene Stokamer (700/662-4218 or email stokamer.charlene@new-york.va.gov) with your input!

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